REHABILITATION IN HAWAII AND THE PACIFIC BASIN: KEIA MUA AKU*

Tim Gust

The future is both exciting and awesome. It is exciting to think and plan creatively, to take into account the many knowns and unknowns, hoping to evolve future solutions for present problems. It is awesome to assume responsibility for shaping future programs to meet human needs.

This article will describe one person's view of the future of rehabilitation in Hawaii and the Pacific Basin. Future projections are an amalgam of fact, assumption, and fantasy. Therefore, it is important to note that this discussion is necessarily subjective. Validity can be debated now, but will only be supported or refuted by future events.

Personal opinions concerning rehabilitation services and professionals, rehabilitation education and training, and the Pacific Basin region as they exist and function are presented as background data. Based on this information, I shall provide an overview of rehabilitation in Hawaii and the Pacific Basin from now on. This future perspective will include a description of projected service needs and programs, with an emphasis upon education and training, and required resources.

Now

Rehabilitation Services

The comprehensive rehabilitation process consists of those services needed by the congenitally or adventitiously disabled individual and his family which he may use to assist himself to restore full membership in society and regain self-respect. The process may be divided into the physical restoration or *medical rehabilitation process* and the personal/social/vocational restoration or *vocational rehabilitation process.* Delineation of these two processes has evolved primarily from response to needs of disabled individuals rather than from predetermined constructs.

Programs of rehabilitation services throughout the United States have developed typically with either a medical or vocational emphasis. Physical medicine and rehabilitation units have been created in hospitals and, in some instances, have developed autonomy as medical rehabilitation centers. Vocational rehabilitation centers generally have expanded from sheltered workshops and work training centers to emphasize the personal/social/vocational services required by disabled persons.

The public State-Federal program of vocational rehabilitation supports both medical and vocational specialities by coordinating a program of physical and vocational restoration services for disabled individuals. Qualification for service is based upon severe impairment with resultant vocational handicapping condition.

Recent emphasis upon consumer involvement in rehabilitation services reinforces the focus upon client independence evident throughout rehabilitation's history. Another important and continuing factor is personalization of service. The rehabilitation counselor provides a one-to-one relationship with the disabled client, from initial contact through planning individualized services and implementation of the program, to client placement in the community. Research has reaffirmed the importance to a helping relationship of an empathic, warm, and genuine contact between client and counselor.

Rehabilitation Professionals

The comprehensive rehabilitation profession consists of those practitioners needed by the disabled individual and his family which he may use to assist himself to restore full membership in society and regain self-respect. The profession may be divided into physical restoration specialists (including, but not limited to, the physiatrist, physical and occupational therapist,

*from now on

prosthetist, orthotist) and the vocational restoration specialists (including, but not limited to, the psychologist, recreation therapist, social worker, vocational counselor, vocational evaluator). The comprehensive rehabilitation profession evolved from the professions of medicine, psychology and education in response to needs of disabled individuals rather than from predetermined constructs.

Public and private programs of rehabilitation service developed in response to needs of disabled persons. They have been staffed by professionals representing various specialties within the disciplines of education, medicine and psychology. As the field of rehabilitation has grown, a "practice" of rehabilitation has emerged, unique from, but inclusive of, each parent discipline.

Rehabilitation Education and Training

Society's attitudes toward disabled persons constitute one of the most important deterrents to the disabled individual's restoring full membership in society and regaining his self-respect. Attitudes toward and by the handicapped maintain minority group status and deny equality of opportunty for disabled citizens.

Rehabilitation education and training must influence attitudes effectively through a carefully planned program of knowledge dissemination and meaningful experience. Rehabilitationists, disabled, and able-bodied community members can form a positive coalition, given opportunities to learn about and experience a comprehensive rehabilitation process which promotes independence and self-respect of disabled persons.

Clinical practice is a critical aspect of all professional rehabilitation education and training. To be optimally effective, clinical practice should occur in a setting where both the medical and vocational rehabilitation processes co-exist and are inter-involved. Such an approach emphasizes the comprehensiveness of the rehabilitation process. Generalist rehabilitation practitioners emerge from this training and general rehabilitationists are vital professionals in the developing rehabilitation programs of Hawaii and the Pacific Basin.

Finally, rehabilitation education and training activities should be centered in community public and private rehabilitation agencies. Educational laboratories created only for training become antiquated and are costly duplications of community practice. Whenever possible, a formal working relationship between rehabilitation educators and practitioners should be developed, permitting development of a mutually advantageous education-practice program.

The Region

As a region, Hawaii and the Pacific Basin is very different from the mainland United States. The uniqueness of geography, culture, and population dispersion is important in rehabilitation and other human services. These factors affect communication within the region, and between parts of the region and the rest of the world. Practical realities of the unusual transportation methods, varied island cultures, differing social and economic values and systems, myriad languages, and rural versus metropolitan life styles are best understood by those who have experienced the region by living here. These realities, together with continuing emphasis upon the extended family in much of the region, dictate a decentralized local approach to rehabilitation service delivery.

From Now On

Future Regional Rehabilitation Needs

To avoid forcing an academic perspective on practitioners in the field, I conducted an informal survey of rehabilitation counselors in Guam, Hawaii and the Trust Territory of the Pacific. Two counselors from each area were asked to respond to the following questions and requested to seek answers to the same questions from at least one client.

1. What kind of growth of rehabilitation services is needed in your area in the future?
2. How will the above help your people?

Responses to these open-ended questions indicated that practitioners and consumers in Hawaii and the Pacific Basin are most concerned with increasing and improving rehabilitation facilities and counseling staff. They also cited a

need for public education regarding disability and rehabilitation. Finally, they expressed a need for a close relationship with and consultation from the University of Hawaii.

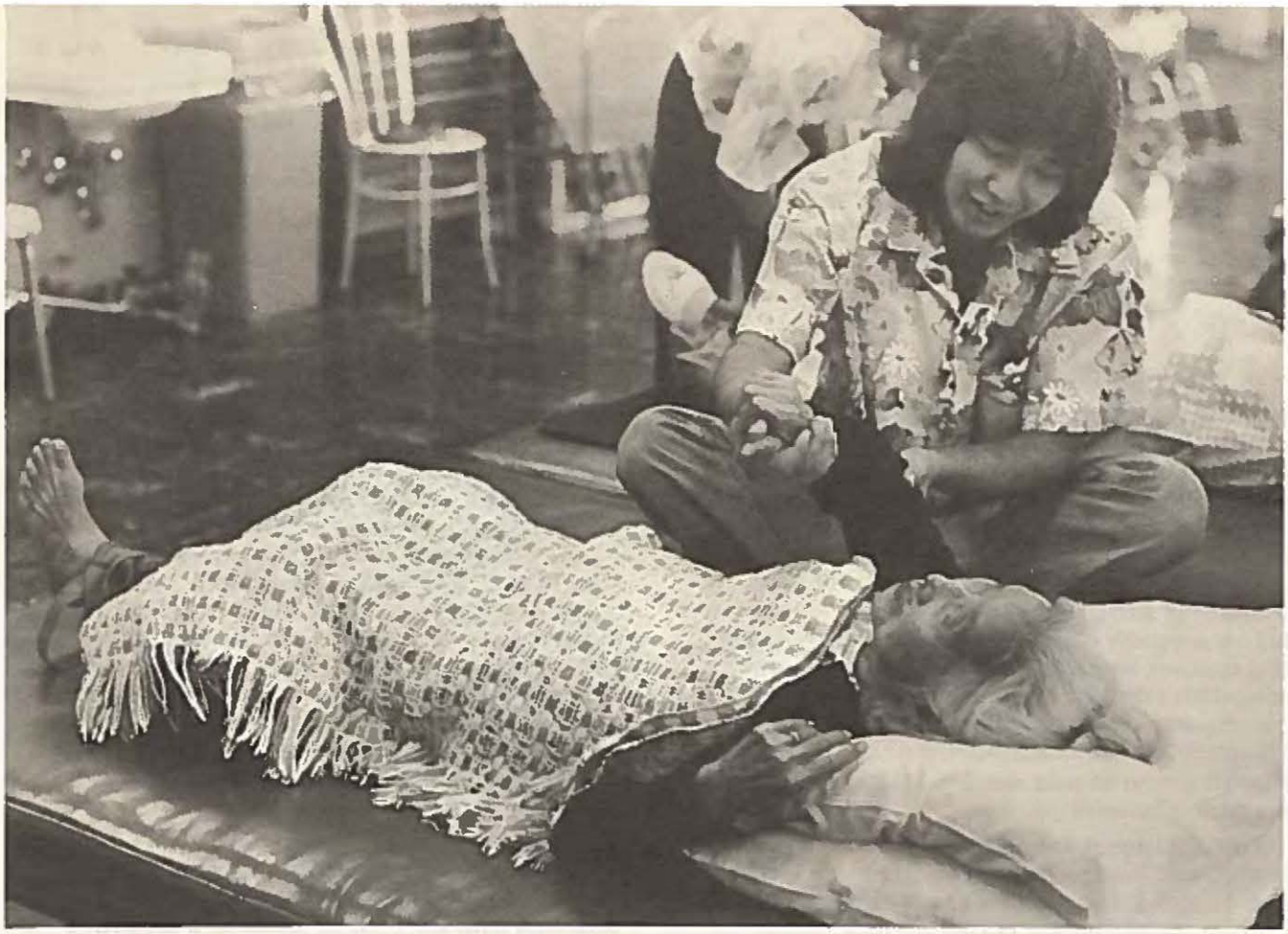
Future Rehabilitation Service Programs

Although others find it difficult to comprehend how life and work in Hawaii and the Pacific Basin are different from the mainland United States, local residents understand and appreciate the uniqueness. Differences from the mainland and within the region described earlier necessitate future emphasis on a local response to local needs in rehabilitation growth. It will be necessary to hold constant rehabilitation's philosophy, goals and objectives while developing unique methodologies to permit effective local rehabilitation practice.

Exciting opportunities exist to create a constellation of rehabilitation services emphasizing consumer and local community involvement. When positive attitudes toward the disabled are nurtured at the local level, communities will be more responsive to receiving and using technical help from rehabilitation professionals. Residents of Hawaii and the Pacific Basin will support a locally based and locally designed rehabilitation program if it is not forced upon them.

We might begin with building understanding and acceptance of disabled persons through working with the key people and groups in each local area. These include family and clan groups, local educators, church groups and existing helping agencies. As local people express their ideas about concerns for disabled in their families, they can be aided in learning how the disabled can be helped through the comprehensive rehabilitation process. The disabled, as part of this overall interaction, can participate with the able-bodied to identify their own needs and concerns and create specific plans to facilitate full participation in their communities.

The local community might best determine what resources are necessary to assist the disabled person to restore full community membership and regain his self-respect. This is especially important in the personal/social/vocational portion of the comprehensive rehabilitation process. The opportunity to work in a small village in the Ponape District of Trust Territory varies from the village of Merizo in Guam, the more developed area of Agana, Guam and the metropolitan area of Honolulu. Cultural values toward money and work likewise vary in these areas. As stated above, the philosophy and objectives of the established rehabilitation program are generally acceptable



from area to area, but methodology of implementation must be unique.

When the geographic vastness of the Trust Territory or the relative isolation of American Samoa is considered, the importance of a locally-based service model is underscored. The idea of traveling to a metropolitan area for services simply does not have validity; many people live most of their lives in a remote village. Transportation problems may preclude effective rehabilitation, if clients must travel to the services. Follow-through necessary to the rehabilitation process must become a cooperative venture among the rehabilitationist, the client, and the local able-bodied community. Specialized medical rehabilitation may of necessity be restricted to regional or district centers due to costs of equipment and specialists. Yet people will need to return to their homes as soon as medical restoration is complete.

Future Rehabilitation Education and Training

Future rehabilitation education and training for Hawaii and the Pacific Basin must follow the concepts of limited centralization, non-duplication, and maximum dispersion. Opportunities for all levels and types of education and training can be developed along these lines.

I visualize the University of Hawaii taking the lead to establish a rehabilitation education training and research program. The program would emphasize graduate level preparation, training of rehabilitation trainers and research to find answers to local problems. There must be close inter-involvement of the University and community rehabilitation practice within such agencies as the Hawaii Vocational Rehabilitation and Services for the Blind Division, Rehabilitation Facilities of Hawaii, Inc., and The Rehabilitation Hospital of the Pacific.

Undergraduate education should be emphasized at many sites, including university and community college campuses in Hawaii, Guam, American Samoa, and the Trust Territory of the Pacific. Through local preparation of rehabilitation personnel, identification of needs and implementation of programs can be facilitated in all areas.

Through a carefully designed continuing education and needs assessment component, the University of Hawaii can continue to offer effective leadership while facilitating a local response to identified needs. The importance of educating able-bodied and disabled citizens within communities has been previously stated. Knowledge and data about rehabilitation and the disabled must be introduced to local com-

munication systems, schools, churches and the public health system. Through a systematic approach of adding rehabilitation content to existing educational programs such as special education, gerontology, allied health, and other human service programs, the integration of community helping services can be promoted. A continuing education and coordinated career ladder program emphasizing community college involvement would make widespread community education feasible. Coursework combined with observation and practicum opportunities in local rehabilitation facilities following the University of Hawaii model should develop viable education-practice relationships.

An educational balance must be found and maintained between taking training to a locale and bringing trainees to a central location. Trainee travel permits maximum opportunity for cross fertilization of individuals and ideas. It is important for rehabilitation practitioners to see what colleagues on different islands or in different areas are doing.

Required Resources

To achieve an effective, responsive rehabilitation service program, a comprehensive education, training and research program is needed. One necessary element of an effective educational program is an organization with adequate financial support. The University of Hawaii is in a unique position to fulfill the need for a comprehensive rehabilitation education, training and research program for Hawaii and the Pacific Basin. However, an organization with adequate financial support is not yet available.

The Rehabilitation Education and Training (RE&T) projects funded by the Rehabilitation Services Administration, Department of Health, Education, and Welfare have been based in Counseling and Guidance in the College of Education since 1971. These projects have demonstrated success in meeting the rehabilitation education and program development needs of Hawaii and the Pacific Basin. Without state support and formal University recognition, a viable RE&T program cannot continue. A Rehabilitation Institute or academic department must be created within the University, supported by local funds supplemented by federal funds. Such a Rehabilitation Institute would implement the described clinical practice, clinical teaching model through a working affiliation with the public and private rehabilitation programs in Hawaii and the Pacific Basin. In addition to the current components of the RE&T program, an added research component would focus upon local problems and knowledge dissemination. Through consultation and continuing education, the Institute would extend to the overall region, the information and technical expertise necessary for viable program development in each locale.

Summary

I have described my perceptions of rehabilitation program, practice, education and training acquired over the past 12 years as a rehabilitation practitioner and educator. I have been privileged to spend the last seven years in Hawaii and the Pacific Basin, working to create a comprehensive rehabilitation program responsive to needs of disabled persons.

My conceptualized future rehabilitation service program with its educational support system may serve as an effective stimulus to all of us to work together to develop a more client-centered rehabilitation program with local cultural integrity carefully preserved.

Tim Gust is Professor, Counseling and Guidance, College of Education, University of Hawaii, and Project Director for the four Rehabilitation Education and Training projects. Receiving his M.Ed. in Counseling and Guidance (1962) and Ph.D. in Counseling Psychology (1964) from the University of North Dakota, Dr. Gust has taught at the University of Pittsburgh and the University of Missouri at Columbia. His experience with the University of Hawaii began in 1969 when he joined the faculty of the Educational Psychology department. Dr. Gust recently returned from sabbatical at San Diego State University where he taught courses in rehabilitation counselor education.